Wisconsin Medicaid Nurse Practitioner Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

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MADISON WI 53701-0309

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Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Associate Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to Wisconsin Medicaid:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Provider Agreement (2 copies)	X		
3.	Degree Affidavit		X	
4.	Skills Acquisition (2 copies) (RCS Providers)	X		
5.	HealthCheck Screener Affirmation		X	
6.	Publications Deletion Form		X	
7.	Publications Addition Form		X	

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Certification Requirements
3.	Terms of Reimbursement
4.	Electronic Billing Information

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance**. This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

NURSE PRACTITIONER CERTIFICATION CRITERIA

Per section HFS 105.20, Wisconsin Administrative Code:

HFS 105.20 Nurse Practitioners:

(1) Qualifications.

For MA certification, a nurse practitioner shall be licensed as a registered nurse pursuant to s. 441.06, Stats., and fulfill one of the following requirements:

(a) If practicing as a pediatric nurse practitioner, be currently certified by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates;

(b) If practicing as any family nurse practitioner, be currently certified by the American Nurses' Association; or

(c) If practicing as any other primary care nurse practitioner or as a clinical nurse specialist, be currently certified by the American Nurses' Association, the National Certification Board of Pediatric Nurse Practitioners and Associates, or the Nurses' Association of the American College of Obstetricians and Gynecologists' Certification Corporation, or have a master's degree in nursing from a school accredited by a program designed to prepare a registered nurse for advanced clinical nurse practice.

(2) Protocols

A written protocal covering a service or delegated medical act that may be provided and procedures that are to be followed for provision of services by nurse practitioners shall be developed and maintained by the nurse practitioner and the delegating licensed physician according to the requirements of s. N 6.03 (2) and the guidelines set forth by the Board of Nursing. This protocol shall include, but is not limited to, explicit agreements regarding those delegated medical acts which the nurse practitioner or clinical nurse specialist is delegated by the physician to provide. A protocol shall also include arrangements for communication of the physician's directions, consultation with the physician, assistance with medical emergencies, patient referrals and other provisions relating to medical procedures and treatment.

History: Cr. Register, February 1986, No. 362, eff. 3-1-86; r. and recr. Register, January 1991, No. 421, eff. 2-1-91.

Provider Type: 45 Revised: May 2000

INDEPENDENT NURSE/RESPIRATORY THERAPIST CERTIFICATION CRITERIA

Per section HFS 105.19, Wisconsin Administrative Code effective March 1, 1993:

HFS 105.19 CERTIFICATION OF NURSES IN INDEPENDENT PRACTICE.

(1) QUALIFICATIONS.

(a) For MA certification to perform skilled nursing services as a nurse in independent practice providing home health services under HFS 107.11(6) or private duty nursing services under s. HFS 107.12, the nurse shall be:

1. Licensed as a registered nurse pursuant to s. 441.06, Stats.;

2. Licensed as a practical nurse pursuant to s. 441.10, Stats.; or

3. A registered nurse providing supervision of a licensed practical nurse certified under this section.

(b) For MA certification to perform respiratory care services as a provider in independent practice, the provider shall be certified pursuant to ch. Med 20 and shall be a nurse described in par. (a) or a respiratory therapist. Any person providing or supervising respiratory care who is not credentialed by the national board on respiratory care shall know how to perform the services under s. HFS 107.113(1) and shall have the skills necessary to perform those services. Skills required to perform services listed in s. HFS 107.113(1)(e) to (f) are required on a case-by-case basis, as appropriate. In no case may a person provide respiratory care before that person has demonstrated competence in all areas under s. HFS 107.113(1)(a) to (d). A registered nurse who fulfills these requirements shall coordinate the recipient's care.

(2) PLAN OF CARE. Nursing services and respiratory care shall be provided in accordance with a written plan of care which the physician reviews and signs at least every 62 days or when the recipient's condition changes, whichever occurs first.

(3) SUPERVISION OF A LICENSED PRACTICAL NURSE. A registered nurse or physician designated by the LPN providing nursing or respiratory care services shall supervise the LPN as often as necessary under the requirements of s. N 6.03 and 6.04(2) and shall document the results of supervisory activities. An LPN may provide nursing or respiratory care services delegated by an RN as delegated nursing acts under ss. N6.03 and 6.04 and guidelines established by the board of nursing.

(4) DUTIES OF THE NURSE.

(a) The following nursing services may be performed only by a registered nurse:

1. Making the initial evaluation visit;

2. Initiating the physician's plan of care and necessary revisions;

3. Providing those services that require care of a registered nurse as defined in ch. N 6;

4. Initiating appropriate preventive and rehabilitative procedures;

5. Accepting only those delegated medical acts which the RN is competent to perform based on his or her nursing education, training or experience; and

6. Regularly reevaluating the patient's needs.

(b) Nursing services not requiring a registered nurse may be provided by a licensed practical nurse under the supervision of a registered nurse. Licensed practical nurse duties include:

1. Performing nursing care delegated by an RN under s. N 6.03;

2. Assisting the patient in learning appropriate self-care techniques; and

3. Meeting the nursing needs of the recipient according to the written plan of care.

(c) Both RNs and LPNs shall:

1. Arrange for or provide health care counseling within the scope of nursing practice to the recipient and recipient's family in meeting needs related to the recipient's condition;

2. Provide coordination of care for the recipient, including ensuring that provision is made for all required hours of care for the recipient;

3. Accept only those delegated medical acts for which there are written or verbal orders and for which the nurse has appropriate training or experience;

4. Prepare written clinical notes that document the care provided within 24 hours of providing service and incorporate them into the recipient's clinical record within 7 days; and

5. Promptly inform the physician and other personnel participating in the patient's care of changes in the patient's condition and needs.

(5) PATIENT RIGHTS. A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge receipt of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

(a) To be fully informed of all rules and regulations affecting the recipient;

(b) To be fully informed of services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;

(c) To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

(d) To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

(e) To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

(f) To be taught and have the family or other persons living with the recipient taught the treatment required, so that the recipient can, to the extent possible, help himself or herself and the family or other party designated by the recipient can understand and help the recipient;

(g) To have one's property treated with respect; and

(h) To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

(6) UNIVERSAL PRECAUTIONS. A nurse shall have the necessary orientation, education and training in epidemiology, modes of transmission and prevention of HIV and other blood-borne or body fluid-borne infections and shall follow universal blood and body-fluid precautions for each recipient for whom services are provided. The nurse shall employ protective measures recommended by the federal centers for disease control (CDC), including those pertaining to medical equipment and supplies, to minimize the risk of infection from HIV and other blood-borne pathogens.

Note: A copy of the CDC recommended universal precautions may be obtained from the Bureau of Quality Assurance, Division of Supportive Living, P.O. Box 309, Madison, Wisconsin 53701.

(7) MEDICAL RECORD. The nurse shall maintain a medical record for each recipient. The record shall document the nature and scope of all services provided and shall be systematically organized and readily accessible to authorized department personnel. The medical record shall document the recipient's condition, problems, progress and all services rendered, and shall include:

(a) Recipient identification information;

(b) Appropriate hospital information, including discharge information, diagnosis, current patient status and post-discharge plan of care;

(c) Recipient admission evaluation and assessment;

(d) All medical orders, including the written plan of care and all interim physician's orders;

(e) A consolidated list of medications, including start and stop dates, dosage, route of administration and frequency. This list shall be reviewed and updated for each nursing visit, if necessary;

(f) Progress notes posted as frequently as necessary to clearly and accurately document the recipient's status and services provided. In this paragraph, "progress note" means a written notation, dated and signed by a member of the health team providing covered services, that summarizes facts about care furnished and the recipient's response during a given period of time;

(g) Clinical notes written the day service is provided and incorporated into the clinical record within 7 days after the visit or recipient contact. In this paragraph, "clinical note" means a notation of a contact with a recipient that is written and dated by a member of the home health team providing covered services, and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition;

(h) Written summaries of the recipient's care provided by the nurse to the physician at least every 62 days; and

(i) Written authorizations from the recipient or the recipient's guardian when it is necessary for the nurse to procure medical supplies or equipment needed by the recipient.

(8) BACK-UP AND EMERGENCY PROCEDURES.

(a) A recipient's nurse shall designate an alternate nurse to provide services to the recipient in the event the nurse is temporarily unable to provide services. The recipient shall be informed of the identity of the alternate nurse before the alternate nurse provides services.

(b) The nurse shall document a plan for recipient-specific emergency procedures in the event a life-threatening situation or fire occurs or there are severe weather warnings. This plan shall be made available to the recipient and all caregivers prior to initiation of these procedures.

(c) The nurse shall take appropriate action and immediately notify the recipient's physician, guardian, if any, and any other responsible person designated in writing by the patient or guardian of any significant accident, injury or adverse change in the recipient's condition.

(9) DISCHARGE OF THE RECIPIENT. A recipient shall be discharged from services provided by the nurse upon the recipient's request, upon the decision of the recipient's physician, or if the nurse documents that continuing to provide services to the recipient presents a direct threat to the nurse's health or safety and further documents the refusal of the attending physician to authorize discharge of the recipient with full knowledge and

understanding of the threat to the nurse. The nurse shall recommend discharge to the physician and recipient if the recipient does not require services or requires services beyond the nurse's capability. The nurse provider shall issue a notification of discharge to the recipient or guardian, if possible, at least 2 calendar weeks prior to cessation of skilled nursing services and shall, in all circumstances, provide assistance in arranging for the continuity of all medically necessary care prior to discharge.

(10) DEPARTMENT REVIEW

(a) Record review. The department may periodically review the records described in this section and s. HFS 106.02(9), subject only to restrictions of law. All records shall be made immediately available upon the request of an authorized department representative.

(b) In-home visits. As part of the review under par. (a), the department may contact recipients who have received or are receiving MA services from a nurse provider. The nurse provider shall provide any identifying information requested by the department. The department may select the recipients for visits and may visit a recipient with the approval of the recipient or recipient's guardian. The recipient to be visited shall be given the opportunity to have any person present whom he or she chooses during the visit by personnel of the department or other governmental investigating agency.

(c) Investigation of complaints. The department may investigate any complaint received by it concerning the provision of MA services by a nurse provider. Following the investigation, the department may issue a preliminary final report to the nurse provider in question, except when doing so would jeopardize any other investigation by the department or other state or federal agency.

HFS 105.19, Wis. Adm. Code, effective March 1, 1993

NURSE MIDWIVES

Per section HFS 105.201, Wis. Adm. Code, effective February 1, 1991: For MA certification, a nurse midwife shall be certified as a registered nurse under s. HFS 105.19 (1) and shall be certified as a nurse midwife under ch. N 4.

Per section HFS 107.121, Wis. Adm. Code, effective February 1, 1991:

(1) COVERED SERVICES. Covered services provided by a certified nurse midwife may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal child-birth and the immediate postpartum period, provided that the nurse-midwife services are provided within the limitations established in s. 441.15 (2), Stats., and ch. N 4.

(2) LIMITATION. Coverage for nurse-midwife services for management and care of the mother and newborn child shall end after the sixth week of postpartum care.

There is not a separate nurse midwife form to complete. Your Medicaid certification/ recertification approval will be based on your current registered nurse (RN) and midwife license/certification to practice.

Nurse midwives with master's degrees are Wisconsin Medicaid certified as nurse practitioners with a nurse midwife specialty. Nurse midwives who do not have a master's degree are certified as independent nurses with a specialty of nurse midwife.

If you have a master's degree it is to your advantage to be certified as a nurse practitioners. Nurse practitioners are reimbursed at a higher level and have more flexibility in billing under Wisconsin Medicaid. An affidavit certifying education level is required for nurse practitioner certification.

NURSE LICENSURE/MED 20 CERTIFICATION

Your current Wisconsin permanent nurse license or Med 20 certification must be verified prior to your certification/recertification. You can expedite this process by sending a copy of your current nurse license and/or Med 20 certificate and by writing your date of birth on it. Send it to Wisconsin Medicaid with your other materials.

A temporary nurse license (permit) will be accepted only from a nurse with a permanent license in another state who applies for a Wisconsin license. Send a copy of both state licenses. A temporary license issued to a recently graduated nurse is not accepted; a permanent license is required. Current Med 20 certification is required for respiratory therapists.

A current RN license and certification as a nurse midwife under ch. N 4 is required for Medicaid nurse midwife certification. If you are a nurse midwife working at a clinic in a border-status location who is licensed to practice as a nurse midwife in your state, send a copy of your current state RN and nurse midwife license and/or certificate to Wisconsin Medicaid.

NEW MEDICAID APPLICANTS AND REINSTATEMENTS AFTER ONE YEAR LAPSE

Carefully read the application memorandum, the certification regulations in HFS 105.19 and HFS 105.201 above and the attached HFS 107 sections of the Wisconsin Administrative Code. If the application is not received by Wisconsin Medicaid within 30 days from the date on the application memorandum, the date that Wisconsin Medicaid receives the correctly completed application will be the effective date. The effective date cannot be earlier than the date the provider meets all certification requirements. Applications for reinstatement after a one-year lapse in certification are processed like new applications, (except a new number is not issued).

PRIOR AUTHORIZATION APPROVAL REQUIRED

Prior authorization (PA) approval is required for skilled private duty nursing services and respiratory care services provided to Medicaid recipients at home. (See the attached copy of HFS 107.12, Wis. Adm. Code, covered private duty nurse services and HFS 107.113, Wis. Adm. Code, covered respiratory care for ventilator assisted recipients services.) Services provided before the PA is approved may not be covered or payable. PA is a completely separate process that follows the certification process. To ensure Medicaid payment, you should obtain the PA approval before starting services. When you receive your provider certification/reinstatement

(after one-year lapse) approval letter, immediately send a correctly completed PA to Wisconsin Medicaid in order to get the earliest possible grant date assigned on the PA, (if the PA is approved).

RESPIRATORY CARE SERVICE (RCS) PROVIDERS

If you are applying for RCS certification/recertification to provide respiratory care services, you must complete and send the attached Adult and/or Pediatric Declaration of Skill Acquisition RCS form(s) to Wisconsin Medicaid with your other certification/recertification documents. The Wisconsin Medicaid Program will review each Declaration and determine if you will be required to obtain further training or work experience before certification/recertification can be approved. Information on suggested training opportunities is attached.

To demonstrate competence, individual RCS (RN, LPN, RT) providers must obtain and renew their skills by attending professional RCS training every two years (24 months). Notice will be sent to advise you when your updated Declaration of Skill Acquisition RCS form(s) is due.

PRIVATE DUTY NURSE (PDN) PROVIDERS

If you are applying for PDN certification/recertification, (not RCS), complete the attached PDN Affidavit and send it to Wisconsin Medicaid with your other certification/recertification documents.

ALL PROVIDERS

Please carefully review the following pages for certification/recertification materials. Make a copy of your completed application/recertification documents for your records before mailing them to Wisconsin Medicaid.

Services provided before the assigned certification/reinstatement effective date, or during a lapse caused by late recertification, are not payable. To ensure payment, providers should wait to provide services until the completed application and PA are approved. For recertification, providers should confirm their recertification is approved to ensure payment of services that will be provided after the due date for the completed recertification materials.

Attachments

Provider Types: 33, 41, 45-RCS

NURSE MIDWIFE
CERTIFICATION CRITERIA

Per Section HFS 105.201, Wis. Adm. Code for MA certification, a nurse midwife shall be certified as a registered nurse under s. HFS 105.19 (1) and shall be certified as a nurse midwife under ch. N 4.

Per Section HFS 107.121, Wis. Adm. Code:

(1) COVERED SERVICES. Covered services provided by a certified nurse midwife may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal child-birth and the immediate postpartum period, provided that the nurse midwife services are provided within the limitations established in s. 441.15 (2), Stats., and ch. N 4.

(2) LIMITATION. Coverage for nurse midwife services for management and care of the mother and newborn child shall end after the sixth week of postpartum care.

There is not a separate nurse midwife form to complete. Your Medicaid certification/ recertification approval will be based on your current registered nurse and midwife license/ certification to practice.

CLINIC CERTIFICATION CRITERIA

Clinics requesting certification are subject to the certification requirements in Chapter HFS 105, Wisconsin Administrative Code, applicable to the individual providers within the clinic who provide services for which reimbursement is requested from the Wisconsin Medicaid program. The clinic itself can request and be issued a billing number in order to bill for services performed by two or more like providers, i.e., two physicians or two therapists, but not one physician and one therapist. In addition, a clinic number can be issued to one provider when that provider performs services at two separate locations and, therefore, wants to separate the billings and reimbursements according to the location where services were provided.

Billing numbers are assigned to clinics strictly as an accounting convenience to allow payments for services performed by individual clinic members to be made directly to the clinic. The billing number has no independent payment capabilities. In order for reimbursement to be made to the clinic, the billing number must be used in conjunction with the performing provider number of the individual provider who performed the service.

Make sure each individual group member is certified with the Wisconsin Medicaid program prior to performing services. Wisconsin Medicaid cannot reimburse for services provided prior to certification of the performing provider.

Provider Types:	19, 20, 27, 28, 29, 30, 31, 32, 33, 34, 35, 37, 38, 43, 45, 78, 84	Effective Date:	February 1, 1991
		Revised:	February 2000

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

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NURSE PRACTITIONER
TERMS OF REIMBURSEMENT

The Department will establish maximum allowable fees for all covered nurse practitioner services provided to Wisconsin Medicaid Program recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the Department. Medicaid reimbursement, less appropriate copayment and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s): 45

Effective Date: April 1, 1991
Renewed: March 2000

DIVISION OF HEALTH CARE FINANCING

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Department of Health and Family Services

NURSE-MIDWIFE
TERMS OF REIMBURSEMENT

The Department will establish maximum allowable fees for all covered nurse-midwife services provided to Wisconsin Medicaid recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medicaid Program, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of Federal funding as specified in Federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the Department. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s):	45/Specialty 142 (Master's Level)	Effective Date:	June 2000
		Effective Date:	April 1, 1991
		Renewed/Revised*:	September, 1997

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RESPIRATORY CARE
TERMS OF REIMBURSEMENT

The Department will establish an hourly contracted rates for all covered respiratory care services provided to ventilator dependent Wisconsin Medicaid Program recipients eligible on the date of service, as mandated by 1989 Wisconsin Act 31. The hourly contracted rates shall be based on various factors, including a review of usual and customary charges submitted to the Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. The hourly contracted rates may be adjusted to reflect reimbursement limits or limits on the availability of Federal funding as specified in Federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider of the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered respiratory care service, the Department shall pay the hourly contracted rate established by the Department. Reimbursement for other home health services provided to ventilator dependent recipients will be in accordance with the applicable Home Health Agency or Private Duty Nurse Terms of Reimbursement. Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting hourly contracted rates for services.

Applicable Provider Type(s): 41/All Specialties
33/Specialties 136, 137
44 (If certified for RCS)

Effective Date: April 1, 1991
Renewed: October 2000

PR08176A.KZ/TOR

WISCONSIN MEDICAID

PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.

2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.

3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.

4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

DISTRIBUTION — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed

Provider Number	Effective Date
Provider Type	**Provider Specialty**

WISCONSIN MEDICAID
PROVIDER APPLICATION

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:

☐ Individual.
☐ Group/Clinic.
☐ Change of Ownership, effective__ __/__ __ /__ __ __ __.

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions

Name — Provider Applicant — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Name — Group or Contact Person — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. Wisconsin Medicaid will send general information and correspondence to this address. Official correspondence will be sent certified. Failure to sign for official correspondence could result in decertification. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Date of Birth — Individual / Social Security Number — Required for individual applicants only. Enter date as MM/DD/YYYY.

Name — Medicaid Contact Person, Telephone Numbers, and Fax Number — List the name, telephone number, and fax number of a person within your organization who can be contacted about Medicaid questions. Also list a telephone number clients can use to reach you. This telephone number must be kept current with Wisconsin Medicaid.

Medicare Part A Number and Medicare Part B Number — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

Name — Provider Applicant (Agency Name or Last, First Name, Middle Initial)

Name — Group or Contact Person

Address — Physical Work

City	State	Zip Code	County

Date of Birth — Individual	SSN	Name — Medicaid Contact Person

Telephone Number — Medicaid Contact Person	Telephone Number — For Client Use	Fax Number

Current and/or Previous State Medicaid Provider Number

☐ Wisconsin ☐ Other

Medicare Part A Number	Effective Date

Medicare Part B Number	Effective Date

SECTION II — ADDITIONAL INFORMATION

Special Instructions
Respond to all applicable items:

- **All applicants must complete question 1. Providers with a physical address in Minnesota, Michigan, Iowa, or Illinois** must attach a copy of their current license.
- **Physicians** must answer **question 2**.
- **Applicants who will bill for laboratory tests** must answer **question 3**. Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 4**.
- **Individuals affiliated with a Medicaid-certified group** must answer **question 5**.

1. Individual or Agency License, Certification, or Regulation Number(s)

2. Unique Physician Identification Number (UPIN)

3. CLIA Number

4. Drug Enforcement Administration (DEA) Number

5. Medicaid Clinic/Group Number

SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions
Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Name — Group or Contact Person (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee

TIN	TIN Effective Date	☐ EIN or ☐ SSN

Name — Group or Contact Person

Address — Payee

City	County	State	Zip Code

SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which you wish to be certified. An individual may choose only one provider type per application.

- ☐ Ambulance.
- ☐ Ambulatory Surgery Center.
- ☐ Anesthesiology Assistant*.
- ☐ Anesthetist CRNA.
- ☐ Audiologist.
- ☐ Audiologist/Hearing Instrument Specialist.
- ☐ Case Management.
- ☐ Chiropractor.
- ☐ Community Care Organization.
- ☐ Dentist, Specialty _____.
- ☐ End Stage Renal Disease.
- ☐ Family Planning Clinic.
- ☐ HealthCheck Screener.
- ☐ HealthCheck "Other" Services:
  - ☐ Other Eligible Services.
- ☐ Hearing Instrument Specialist.
- ☐ Home Health Agency:
  - ☐ With Personal Care.
  - ☐ With Respiratory Care.
- ☐ Hospice.
- ☐ Independent Lab.
- ☐ Individual Medical Supply:
  - ☐ Orthodontist and/or: Prosthetist.
    Other _____.
- ☐ Medical Vendor/Durable Medical Equipment (DME).
- ☐ Nurse Practitioner:
  - ☐ Certified Nurse Midwife (masters level or equivalent).
- ☐ Nurse Services (Independent Home Care):
  - ☐ Respiratory Care Services.
  - ☐ Private Duty.
  - ☐ Midwife.
- ☐ Occupational Therapy (OT).
- ☐ OT Assistant*.
- ☐ Optician.
- ☐ Optometrist.
- ☐ Osteopath (See below).
- ☐ Osteopath Group/Clinic (See below).
- ☐ Personal Care Agency.
- ☐ Pharmacy.
- ☐ Physical Therapy (PT).
- ☐ PT Assistant*.
- ☐ Physician (See below).
- ☐ Physician Assistant*.
- ☐ Physician Group/Clinic (See below).
- ☐ Podiatrist.
- ☐ Portable X-ray.
- ☐ Prenatal Care Coordination (PNCC).
- ☐ Rehabilitation Agency.
- ☐ Respiratory Therapist.
- ☐ Rural Health Clinic.
- ☐ School-Based Services.
- ☐ Specialized Medical Vehicle Transportation.
- ☐ Speech and Hearing Clinic.
- ☐ Speech and Pathology:
  - ☐ Master's Level.
  - ☐ Bachelor's Level*.
- ☐ Therapy Group (Two therapies, i.e., OT and PT).
- ☐ Others (Describe): _____
  _____.

*Individuals must be supervised and cannot independently bill Wisconsin Medicaid. In most cases, the clinic must submit claims.

Osteopaths or physicians, or a group/clinic of an osteopath or physician, must indicate the specialty below (select one specialty):

- ☐ Allergy.
- ☐ Anesthesiology.
- ☐ Cardiovascular Disease.
- ☐ Clinic.
- ☐ Dermatology.
- ☐ Ear, Nose, Throat Otorhinolaryngology.
- ☐ Emergency Medicine.
- ☐ Family Practice.
- ☐ Gastroenterology.
- ☐ General Practice.
- ☐ General Surgery.
- ☐ Geriatrics.
- ☐ Internal Medicine.
- ☐ Manipulative Therapy.
- ☐ Miscellaneous.
- ☐ Nephrology.
- ☐ Neurological Surgery.
- ☐ Neurology.
- ☐ Nuclear Medicine.
- ☐ Obstetrics and Gynecology.
- ☐ Oncology and Hematology.
- ☐ Ophthalmology.
- ☐ Optometry.
- ☐ Orthopedic Surgery.
- ☐ Pathology.
- ☐ Pediatrics.
- ☐ Pediatric Allergy.
- ☐ Pediatric Cardiology.
- ☐ Physical Medicine and Rehab.
- ☐ Plastic Surgery.
- ☐ Preventive Medicine.
- ☐ Proctology.
- ☐ Psychiatry (MDs attach a proof of completed psychiatric residency).
- ☐ Pulmonary Disease.
- ☐ Radiation Therapy.
- ☐ Radiology.
- ☐ Thoracic and Cardiovascular Surgery.
- ☐ Urgent Care.
- ☐ Urology.

SECTION V — MEMBERS OF GROUP OR CLINIC

Required: If this application is for a group or clinic, complete the chart below by listing all individuals providing Medicaid services at the clinic.

Name — Provider	Address — Provider Physical Work	Specialty	License Number	Provider Number

SECTION VI — APPLICANT'S TYPES OF SERVICE PROVIDED AND TYPE OF BUSINESS

1. List the types of Medicaid services the applicant's agency will provide (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).

2. Applicant's type of business (check appropriate box):

- ☐ Individual.
- ☐ Sole Proprietor:
  County and state where registered _____.
- ☐ Corporation for Nonprofit.
- ☐ Limited Liability.
- ☐ Corporation for Profit.
  State of registration _____

  Names of corporate officers _____

  _____
- ☐ Partnership.
  State of registration _____.

  Names of all partners and SSNs (use additional sheet if needed):

  Name _____ SSN _____

  Name _____ SSN _____

Governmental (check one):

- ☐ County.
- ☐ State.
- ☐ Municipality (city, town, village).
- ☐ Tribal.

- ☐ Other, specify _____.

Definitions for Sections VII-IX

Controlling interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION VII — TERMINATION / CONVICTION / SANCTION INFORMATION

Has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

SECTION VIII — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy?

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section IX.

Name			
Medical Provider Number(s)	SSN/EIN		
Address			
City	State	Zip Code	County

Telephone Number— Business	Telephone Number— Home	Type and percentage of controlling interest or ownership

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION IX — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☑ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Individual or Entity			
Address			
City	State	Zip Code	County
Telephone Number— Business	Telephone Number— Home	Type and percentage of controlling interest or ownership	
SSN or IRS Tax Number	Provider Number, if applicable		

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

DEGREE AFFIDAVIT

TO: Provider Maintenance
Wisconsin Medicaid
6406 Bridge Road
Madison, WI 53784-0006

I hereby certify that _____ received a master's degree in nursing from this institution on _____ and that the course of study completed prepared this person for a role as a registered nurse in advanced clinical nursing practice. The curriculum completed is accredited by _____.

SIGNED: _____

TITLE: _____

COLLEGE/
UNIVERSITY: _____

ADDRESS: _____

_____

DATE: _____

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

WISCONSIN MEDICAID PROGRAM
DECLARATION OF SKILL ACQUISITION - RESPIRATORY CARE SERVICES (RCS)
ADULT (Age 17 and Over)

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

(Print) LAST NAME	FIRST NAME	MI	MAIDEN NAME (if applicable)	Medicaid Prov. # (New Applicants Skip)

Check all boxes which apply:

1. ☐ Licensed as a registered nurse pursuant to s. 441.06, Stats.
2. ☐ Licensed as a practical nurse pursuant to s. 441.10, Stats.
3. ☐ Respiratory Therapist certified by the Wisconsin Medical Examining Board pursuant to ch. Med 20.
4. ☐ Credentialed by the National Board for Respiratory Care: Attach a copy of your certificate.

The following items are the minimum skills and knowledge requirements you must meet to be certified pursuant to s. HFS 105.19(1)(b), Wisconsin Administrative Code, (certification), to provide respiratory care services described under s. HFS 107.113, Wisconsin Administrative Code, (covered services), to Medicaid recipients. (See the attached copy of s. HFS 105.19 and HFS 107.113.)

Complete the chart that follows and the signature section on Page 4. You must provide a response in each box following each procedure. If you send this Declaration to Wisconsin Medicaid incomplete, it will be returned to you and will delay approval. Since certification criteria must be met on an ongoing and continuous basis, all RCS providers (RN, LPN and RT) must renew their skills by attending professional RCS training every two years (24 months).

A response of Yes in Column A for all fifteen procedures is a minimum requirement for certification. The date(s) for Column B should be the most recent date(s) these skills were updated by attending RCS training for adult care.

Acceptable responses for Column C are hospitals accredited by the Joint Commission of Health Care Organizations or nursing homes state approved for ventilator care.

If you need more space for your response in Columns C and D, please attach additional pages as needed.

Procedure	A. Skill Acquired For Adult Care? (Yes or No)	B. Date(s) Skill(s) Acquired (Attended Training)	C. Record Your RCS Training From an Approved Facility Within Past Two Years: Include Facility Where Skill(s) Acquired, Contact Person(s) and Institution(s) Address(es) and Telephone Number(s)	D. Record Your Past Work Experience Within Past Two Years: Include Start and End Dates When You Performed RCS Skills On Adult Patients and Where Performed [Facility Name(s), Address(es), Contact Person(s) and Phone Number(s)]
1. Airway management, including tracheostomy care, changing of a tracheostomy tube and procedures in the event of accidental extubation or mucous plug.				
2. Tracheal suctioning techniques consistent with pulmonary hygiene techniques.				
3. Airway humidification.				
4. Oxygen therapy including operation of oxygen systems and auxiliary oxygen delivery devices.				
5. Respiratory assessment including monitoring of breath sounds, patient color, chest excursion, secretions and vital signs.				
6. Ventilator management: operation of positive pressure ventilator by means of a tracheostomy including, but not limited to, different modes of ventilation, types of alarms and responding to alarms, troubleshooting ventilator dysfunction.				
7. Knowledge of weaning a patient from the ventilator.				
8. Chest physiotherapy (Optional in adults).				
9. Medication administration including administration of aerosolized medications and assessment of their actions and effects.				

Procedure	A. Skill Acquired For Adult Care? (Yes or No)	B. Date(s) Skill(s) Acquired (Attended Training)	C. Record Your RCS Training From an Approved Facility Within Past Two Years: Include Facility Where Skill(s) Acquired, Contact Person(s) and Institution(s) Address(es) and Telephone Number(s)	D. Record Your Past Work Experience Within Past Two Years: Include Start and End Dates When You Performed RCS Skills On Adult Patients and Where Performed [Facility Name(s), Address(es), Contact Person(s) and Phone Number(s)]
10. Documentation of service:				
• Content: N6.03 standards of practice/ nursing process - developing a narrative.				
• Sample flow sheets.				
11. Operation and assembly of ventilator circuit (delivery system).				
12. Proper cleaning and disinfection of equipment.				
13. Operation of a manual resuscitator.				
14. Emergency assessment and management.				
15. CPR (most recent certification identified under "Date(s) skill(s) acquired"/Column B). **ATTACH a copy of your current/valid American Red Cross or American Heart Association certification card.**				

ATTACH A COPY OF THE INSTITUTION'S DATED CURRICULUM, CHECKLIST, SYLLABUS, OR CERTIFICATE THAT VERIFIES YOU SUCCESSFULLY COMPLETED ADULT TRAINING AND DEMONSTRATED COMPETENCE IN ALL OF THE VENTILATOR CARE SKILLS ON PAGES 2 and 3 FOR ADULT CARE. IF NONE OF THESE DOCUMENTS ARE AVAILABLE, A LETTER FROM THE TRAINING INSTITUTION (NOT AN INDIVIDUAL) WILL BE ACCEPTABLE. THE LETTER MUST STATE: THE DATE(S) OF TRAINING; TRAINING WAS FOR ADULT CARE; AND THAT YOU DEMONSTRATED COMPETENCE IN ALL OF THESE VENTILATOR CARE SKILLS FOR ADULT PATIENTS.

When your correctly completed Adult and/or Pediatric RCS Declaration with attachments and other required Medicaid certification/recertification documents are received and reviewed, you will receive a notification letter of approval, or instructions on how to get approved.

PRIOR AUTHORIZATION APPROVAL REQUIRED

Prior Authorization (PA) approval is required for RCS-certified providers. PA is a separate process that follows the certification process. If you are applying for initial Medicaid certification, you will need your provider number to send your request for PA. When you receive your Medicaid approval letter and provider number, immediately send your PA request. Medicaid cannot ensure payment of any services which are provided before the PA is received and approved. If you start services before the PA is approved, they may not be covered or payable Medicaid services.

In order to get PA approval to provide services to an adult respiratory compromised patient, you must have adult RCS training documented in an approved Declaration. In order to get PA approval to provide services to a pediatric respiratory compromised patient, you must have pediatric RCS training documented in an approved Declaration. To get PA approval to provide services to both adult and pediatric respiratory compromised patients, you must have RCS training for both documented in both Declarations which are approved.

SIGNATURE

I certify that I fully understand the contents of this Declaration and the information I have provided is accurate. I have read the attached Wisconsin Administrative Code s. HFS 105.19 certification regulations and covered services s. HFS 107.113 regulations and understand that as an individual RCS-certified provider, I must meet these and all Medicaid rules on a continuous basis. If the Department of Health and Family Services finds that I have falsified or misrepresented any facts relating to my competency to provide Respiratory Care Services to Medicaid recipients, I understand that my certification as a Medicaid provider will be terminated and Medicaid payments I have received will be paid back.

Signature	Date	( ) Home Telephone Number

Home Street Address	City	State	Zip

WISCONSIN MEDICAID PROGRAM
DECLARATION OF SKILL ACQUISITION - RESPIRATORY CARE SERVICES (RCS)
PEDIATRIC (AGE 0-16)

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

(Print) LAST NAME	FIRST NAME	MI	MAIDEN NAME (if applicable)	Medicaid Prov. # (New Applicants Skip)

Check all boxes which apply:

1. ☐ Licensed as a registered nurse pursuant to s. 441.06, Stats.
2. ☐ Licensed as a practical nurse pursuant to s. 441.10, Stats.
3. ☐ Respiratory Therapist certified by the Wisconsin Medical Examining Board pursuant to ch. Med 20.
4. ☐ Credentialed by the National Board for Respiratory Care: Attach a copy of your certificate.

The following items are the minimum skills and knowledge requirements you must meet to be certified pursuant to s. HFS 105.19(1)(b), Wisconsin Administrative Code, (certification), to provide respiratory care services described under s. HFS 107.113, Wisconsin Administrative Code, (covered services), to Medicaid recipients. (See the attached copy of s. HFS 105.19 and HFS 107.113.)

Complete the chart that follows and the signature section on Page 4. You must provide a response in each box following each procedure. If you send this Declaration to Wisconsin Medicaid incomplete, it will be returned to you and will delay approval. Since certification criteria must be met on an ongoing and continuous basis, all RCS providers (RN, LPN and RT) must renew their skills by attending professional RCS training every two years (24 months).

A response of Yes in Column A for all fifteen procedures is a minimum requirement for certification. The date(s) for Column B should be the most recent date(s) these skills were updated by attending RCS training for pediatric care.

The only acceptable response for Column C is a hospital which is accredited by the Joint Commission of Health Care Organizations.

If you need more space for your response in Columns C and D, please attach additional pages as needed.

Procedure	A. Skill Acquired For Pediatric Care? (Yes or No)	B. Date(s) Skill(s) Acquired (Attended Training)	C. Record Your RCS Training From an Approved Training Facility Within Past Two Years: Include Hospital Where Skill(s) Acquired, Contact Person(s) and Hospital(s) Address(es) and Telephone Number(s)	D. Record Your Past Work Experience Within Past Two Years: Include Start and End Dates When You Performed RCS Skills On Pediatric Patients and Where Performed [Facility Name(s), Address(es), Contact Person(s) and Phone Number(s)]
1. Airway management, including tracheostomy care, changing of a tracheostomy tube and procedures in the event of accidental extubation or mucous plug.				
2. Tracheal suctioning techniques consistent with pulmonary hygiene techniques: • Use of normal saline lavage.				
• Knowledge of manual ventilation during trach suctioning or changes.				
3. Airway humidification.				
4. Oxygen therapy including operation of oxygen systems and auxiliary oxygen delivery devices.				
5. Respiratory assessment including monitoring of breath sounds, patient color, chest excursion, secretions and vital signs.				
6. Ventilator management: operation of positive pressure ventilator by means of a tracheostomy including, but not limited to, different modes of ventilation, types of alarms and responding to alarms, troubleshooting ventilator dysfunction.				
7. Knowledge of weaning a patient from the ventilator.				
8. Chest physiotherapy.				

Procedure	A. Skill Acquired For Pediatric Care? (Yes or No)	B. Date(s) Skill(s) Acquired (Attended Training)	C. Record Your RCS Training From an Approved Training Facility Within Past Two Years: Include Hospital Where Skill(s) Acquired, Contact Person(s) and Hospital(s) Address(es) and Telephone Number(s)	D. Record Your Past Work Experience Within Past Two Years: Include Start and End Dates When You Performed RCS Skills On Pediatric Patients and Where Performed [Facility Name(s), Address(es), Contact Person(s) and Phone Number(s)]
9. Medication administration including administration of aerosolized medications and assessment of their actions and effects.				
10. Documentation of service:				
• Content: N6.03 standards of practice/ nursing process - developing a narrative.				
• Sample flow sheets.				
11. Operation and assembly of ventilator circuit (delivery system).				
12. Proper cleaning and disinfection of equipment.				
13. Operation of a manual resuscitator.				
14. Emergency assessment and management.				
15. CPR (most recent certification identified under "Date(s) skill(s) acquired"/Column B). **ATTACH a copy of your current/valid American Red Cross or American Heart Association certification card.**				

ATTACH A COPY OF THE HOSPITAL'S DATED CURRICULUM, CHECKLIST, SYLLABUS, OR CERTIFICATE THAT VERIFIES YOU SUCCESSFULLY COMPLETED PEDIATRIC TRAINING AND DEMONSTRATED COMPETENCE IN ALL OF THE VENTILATOR CARE SKILLS ON PAGES 2 and 3 FOR PEDIATRIC CARE. IF NONE OF THESE DOCUMENTS ARE AVAILABLE, A LETTER FROM THE TRAINING HOSPITAL (NOT AN INDIVIDUAL) WILL BE ACCEPTABLE. THE LETTER MUST STATE: THE DATE(S) OF TRAINING; TRAINING WAS FOR PEDIATRIC CARE; AND THAT YOU DEMONSTRATED COMPETENCE IN ALL OF THESE VENTILATOR CARE SKILLS FOR PEDIATRIC PATIENTS.

When your correctly completed Adult and/or Pediatric RCS Declaration with attachments and other required Medicaid certification/recertification documents are received and reviewed, you will receive a notification letter of approval, or instructions on how to get approved.

PRIOR AUTHORIZATION APPROVAL REQUIRED

Prior Authorization (PA) approval is required for RCS-certified providers. PA is a separate process that follows the certification process. If you are applying for initial Medicaid certification, you will need your provider number to send your request for PA. When you receive your Medicaid approval letter and provider number, immediately send your PA request. Medicaid cannot ensure payment of any services which are provided before the PA is received and approved. If you start services before the PA is approved, they may not be covered or payable Medicaid services.

In order to get PA approval to provide services to an adult respiratory compromised patient, you must have adult RCS training documented in an approved Declaration. In order to get PA approval to provide services to a pediatric respiratory compromised patient, you must have pediatric RCS training documented in an approved Declaration. To get PA approval to provide services to both adult and pediatric respiratory compromised patients, you must have RCS training for both documented in both Declarations which are approved.

SIGNATURE

I certify that I fully understand the contents of this Declaration and the information I have provided is accurate. I have read the attached Wisconsin Administrative Code s. HFS 105.19 certification regulations and covered services s. HFS 107.113 regulations and understand that as an individual RCS-certified provider, I must meet these and all Medicaid rules on a continuous basis. If the Department of Health and Family Services finds that I have falsified or misrepresented any facts relating to my competency to provide Respiratory Care Services to Medicaid recipients, I understand that my certification as a Medicaid provider will be terminated and Medicaid payments I have received will be paid back.

Signature	Date	( ) Home Telephone Number

Home Street Address	City	State	Zip

HealthCheck

HealthCheck is Wisconsin's Early and Periodic Screening Diagnosis and Treatment Program (EPSDT). It is comprehensive preventive health screening for children through the age of 20 who are on Medicaid. HealthCheck calls for early and periodic screenings. The maximum number of comprehensive screens allowed is based on recommendations from the American Academy of Pediatrics:

- Birth to first birthday — 6 screenings
- First birthday to second birthday — 3 screenings
- Second birthday to third birthday — 2 screenings
- Third birthday to twenty-first birthday — 1 screen per year

Comprehensive Screening Examinations

A provider must assess and document all the following components for Wisconsin Medicaid to recognize it as a HealthCheck screen:

- √ A comprehensive health and development history
- √ A comprehensive unclothed physical exam
- √ An age-appropriate vision screen
- √ An age-appropriate hearing screen
- √ An oral assessment plus direct referral to a dentist beginning at age three
- √ Appropriate immunizations, and
- √ Appropriate laboratory tests

HealthCheck "Other Services"

Wisconsin Medicaid must pay for medically necessary medical services to "correct or ameliorate a physical or mental condition," identified through a HealthCheck screen, even if that service is not normally covered. In Wisconsin, we call this HealthCheck "Other Services." Wisconsin

Medicaid has anticipated several potential areas of service that may be needed to meet this requirement, including intensive in-home psychotherapy, adolescent day treatment, certain dental services and otherwise non-covered over-the-counter medications.

Prior authorization is necessary for most of these services. They must meet all the following criteria:

- √ The child must have received a comprehensive HealthCheck screening within one year prior to the request.
- √ The service must be allowed as a medical service.
- √ The service is medically necessary and reasonable.
- √ The service not a covered service under the current Medicaid program.
- √ The requested service may be approved only if no covered service is appropriate to treat the condition.

How to Become a HealthCheck Provider

Medicaid-certified primary care physicians a certified pediatric nurse, or family nurse practitioner are automatically certified for HealthCheck. Other physician specialties, physician assistants and nurse practitioners are encouraged to request certification as HealthCheck providers. Public health agencies and certain other providers, where physician supervision is available, may apply for certification as a HealthCheck agency. Interested applicants may write to Wisconsin Medicaid at the address below to obtain application materials:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

HEALTHCHECK SCREENER AFFIRMATION

ELIGIBLE PROVIDERS

I hereby affirm that _____ is eligible for certification under Section 105.37, Wisconsin Administrative Code, as a provider of HealthCheck health assessment and evaluation services and is the following type of provider of health services:

(Check one)

___ 1. Physician

___ 2. Nurse Practitioner

___ 3. Outpatient hospital facility

___ 4. Health maintenance organization

___ 5. Local public health agency

___ 6. Visiting nurse association

___ 7. Home health agency

___ 8. Rural health clinic

___ 9. Indian health agency

___ 10. Neighborhood health center

___ 11. Clinic operated under a physician's supervision

Please describe the kind of clinic and the formal supervisory relationship with the Physician:

_____

_____

___ 12. Other

If you do not fit any of the categories above, which are stated in HFS 105.37 of the Wisconsin Administrative Code, but can respond affirmatively to the balance of this affirmation, you may request a waiver of the requirements of this section by following the instructions located in Section HFS 106.13.

PROCEDURES AND PERSONNEL REQUIREMENTS

As a provider of HealthCheck services, I/we shall provide periodic comprehensive child health assessments and evaluations of the general health, growth, development, and nutritional status of infants, children, and youth. Immunizations shall be administered at the time of screening if determined medically necessary and appropriate. The results of a health assessment and evaluation shall be explained to the recipient's parent or guardian and to the recipient if appropriate.

Assessments and evaluations shall be performed only by personnel who meet the requirements stated below. Documentation of meeting the requirements stated below will be maintained as part of the individual provider's personnel file and will be available for review by the Wisconsin Medicaid program. A list of the skilled medical personnel and registered nurses currently performing HealthCheck services is attached with the following information: 1) Name or description of course, 2) who gave the course, 3) month/year the course was completed. (A transcript with the information highlighted will be accepted for any individual.)

Skilled Medical Personnel

HealthCheck assessment and evaluation services shall be delivered under the supervision of skilled medical personnel within their scope of practice as allowed by state and federal law. Skilled medical personnel are physicians, physician assistants, nurse practitioners, public health nurses, or registered nurses. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an in service training course on physical assessments.

Paraprofessional Staff

Paraprofessional staff may complete individual procedures, as allowed by law, under the appropriate supervision of qualified medical personnel.

All conditions uncovered which warrant further care shall be diagnosed or treated, or both, by the provider, if appropriate, or referred to other appropriate providers. A referral may either be a direct referral to the appropriate health care provider, or a referral recommendation submitted through the agency responsible for the patient's case management and advocacy.

Health maintenance organizations and prepaid health plans providing HealthCheck services shall meet all requirements of 42 CFR 441.60, in addition to the requirements under subds. 1 to 3.

RECORDS AND DOCUMENTATION

As a provider of HealthCheck services, I/we shall:

Complete an individual health and developmental history for each client and maintain a file on each client receiving HealthCheck services. This file will include a copy of the health and developmental history and follow-up for necessary diagnosis and treatment services.

SKILLED MEDICAL PERSONNEL AND REGISTERED NURSES

Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

Given by____ MO/YR Completed_____________

Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

Given by____ MO/YR Completed_____________

Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

Given by____ MO/YR Completed_____________

Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

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Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

Given by____ MO/YR Completed_____________

Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

Given by____ MO/YR Completed_____________

Name________________________________ Type of Provider (MD, PA, NP, PHN, RN)______

Course____

Given by____ MO/YR Completed_____________

I/we shall release information on the results of the health assessment to appropriate health care providers and health authorities when authorized by the patient or the patient's parent or guardian to do so.

Affirmation

I hereby affirm that, to the best of my knowledge, all of the above are true representations and that the qualification of newly hired personnel will comply with the above requirements.

Signed:_____ Date:_____

_____
(Printed Name/Title)

_____
(HealthCheck Provider)

_____
(Provider Street Address)

_____
(City/State/ZIP)

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11015 (12/02)

WISCONSIN MEDICAID
DELETION FROM PUBLICATIONS MAILING LIST

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Any individual provider who does not wish to receive handbooks*, Wisconsin Medicaid and BadgerCare Updates*, and bulletins under his or her individual provider number must read the following statement, sign it, and date it. Proxy signatures are not acceptable because the individual provider remains responsible for following Wisconsin Medicaid rules and regulations. Requests to discontinue receiving materials will not be processed without individual provider signatures and dates.

This authorizes Wisconsin Medicaid not to send me the Wisconsin Medicaid publications (e.g., handbooks, *Updates*, and bulletins) under my provider number as indicated below. This authorization will remain in effect until I am recertified as a Medicaid provider (usually a period of three years), at which time I will have another opportunity to elect whether to receive these publications.

This action will not affect my status as a Wisconsin Medicaid provider.

I am aware that I am personally responsible for compliance with all Wisconsin Medicaid billing and policy requirements specified in any publication, regardless of whether I personally receive or review those publications.

I choose not to receive these publications because:
- Another person or entity acts as my agent in billing and other relations with Wisconsin Medicaid.
- I have access to these publications through another source, such as a clinic in which I render services.

Name — Provider	Medicaid Provider Number
SIGNATURE — Provider	Date Signed

DISTRIBUTION: Send completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Wisconsin Medicaid
Additional Publications Request Form

Please attach all individual providers' copies of the "Deletion from Publications Mailing List Form" to this sheet. You must have one of these forms attached for each additional copy of publications you are requesting.

Name of Group or Clinic _____

Group/Clinic Provider Number _____

Address _____

_____

_____

Requested number of additional copies of future publications _____

_____

Authorized Signature Date

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DOH 1111A (Rev. 9.97)
DHFS/HEALTH
Wis. Adm. Code HSS 105.01

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(Standard: for individual and most clinic/group/agency providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

Provider Name: _____,
(Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents)
a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program.

4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

(a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

(b) the names and addresses of all persons who have a controlling interest in the Provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the Provider and any subcontractor;

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title 20 services programs since the inception of those programs.

5. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108, Wisconsin Administrative Code, and required by federal or state statute, regulation, or rule for the provision of the service.

6. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid Program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

8. This agreement may be terminated as follows:

   (a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

   (b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services."

SIGNATURES FOLLOW ON PAGE 3

ALL <u>THREE</u> PAGES OF THIS PROVIDER AGREEMENT <u>MUST</u> BE RETURNED TOGETHER.

_____ Name of Provider (Typed or Printed)	(For Department Use Only) STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
_____ Physical Street Address	
_____ City State Zip	
TITLE:_____	
BY:_____ Signature of Provider	**BY:**_____
DATE:_____	**DATE:**_____

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

<u>PRINT CLEARLY, THIS IS YOUR MAILING LABEL.</u> For recertification (renewals) ONLY. Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

_____
_____
_____
_____

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
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Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DOH 1111A (Rev. 9.97)
DHFS/HEALTH
Wis. Adm. Code HSS 105.01

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

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(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the Provider and any subcontractor;

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title 20 services programs since the inception of those programs.

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DATE:_____	**DATE:**_____

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<u>PRINT CLEARLY, THIS IS YOUR MAILING LABEL.</u> For recertification (renewals) ONLY. Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

_____
_____
_____
_____

WISCONSIN MEDICAID
ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: http://www.dhfs.state.wi.us/medicaid9/pes/pes.htm or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.